Arizona Dept. of Health Services Division of Behavioral Health Services

Encounter Tidbits

Arizona Department of Health Services

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HIPAA Corner… … …

Remember These Exceptions to HIPAA

Published July 2004

Not all protected health information is treated the same under the privacy rule. Sometimes patients don't have the right to keep their information private. Your organization has the responsibility to release information regardless of whether a patient approves, because another law requires disclosure to a government or law enforcement agency.

Six reasons to release confidential information without authorization

1. State health agencies require providers to report when patients have certain communicable diseases, even if the patient doesn't want the information reported.
2. The Food and Drug Administration requires providers to report certain information about medical devices that break or malfunction.
3. Some states require physicians and other caregivers who suspect child abuse or domestic violence to report it to the police.
4. Police have the right to request certain information about patients to determine whether they are suspects in a criminal investigation or to assist them in locating a missing person, material witness, or suspect.
5. The courts have the right to order providers to release patient information.
6. Providers must report cases of suspicious deaths or suspected crime victims.

In all of these cases, make sure your organization complies with the law and reports all information when necessary. If reporting this information is part of your job, follow your facility's policy on what types of documentation to require of those requesting information. Never give out PHI without confirming that the person or agency requesting the information has a legal right to it.

This excerpt is adapted from the HIPAA Training Handbook for HIM Staff: Privacy, Security, and Patients' Rights under HIPAA.

Data Validation Study Updates

CY20: The preliminary findings were received and the results forwarded to each RBHA for review. Each RBHA should confirm or challenge the validity of the reported errors. Your review should compare data from the medical records, ADHS/DBHS, and AHCCCS eligibility records, AHCCCS coverage of the service provided, and AHCCCS provider registration or other data sources, if available. Each challenge must be supported by documentation, including but not limited to, CIS screen prints, PMMIS screen prints and screen prints from your internal systems.

Any challenges and supporting documentation should be sent to:

Arizona Department of Health Services/BHS
Office of Program Support
Janice Hippe, CPC
150 N 18th Avenue, Suite 200
Phoenix, Arizona 85007

The Office of Program Support will compile the documentation submitted and forward the challenges in one group. Documentation should be specific and easy to understand, as ADHS/DBHS will not have the time to ***translate*** your challenges. All documentation must be received by October 7, 2004, if we do not hear from you by that date; AHCCCS will use the preliminary results in the final calculation.

ADHS/DBHS will submit a unified challenge to AHCCCS for all of the RBHAs. ***Remember***, this is the only opportunity for the RBHAs to challenge AHCCCS on the CY20 errors.

CY21: AHCCCS' Medical Record collection process is finished, with all of the RBHAs submitting the required 95% or better of the requested medical records by the due date.

Thanks to all of the RBHAs for their hard work on this accomplishment.

Important Information on Corporate Compliance

Health Care Fraud:

- A deception deliberately practiced in order to secure unfair or unlawful gain.
- A piece of trickery; a trick.
- One that defrauds; a cheat.
- One who assumes a false pose; an impostor.

Edit Alerts

An Edit Alert is a faxed and e-mailed notice of system enhancements or changes. The Office of Program Support strives to ensure any system enhancements or changes are communicated to all program participants in an accurate and reliable manner. Edit Alerts will be distributed when the information is first made available and again with the following monthly publication of the Encounter Tidbits.

UB Ancillary Lines with Zero Units or Dollars

In an effort to continually improve the encounter data and data quality, ADHS/DBHS will no longer accept any UB encounters with units and/or billed charges on any ancillary lines having a value of zero (0). Only voids should have both Units and Dollar values equal to zero (0). Our objective is to value each encounter properly so rate setting and other analyses are not negatively impacted.

Incorrect Billing

Line	Rev Cd	Units	Charges	NonCovChg	Description
01	134	5	3650.00	000.00	Psych/3&4 Bed
02	251	1	0.00	000.00	Drugs/Generic
03	301	32	0.00	000.00	Lab/Chemistry
04	302	1	0.00	000.00	Lab/Immunology
05	305	1	0.00	000.00	Lab/Hematology

If this UB were presented, a failure for CIS pre-processor edit, N228 UB ancillary line with zero units or dollars, would be recorded.

Possible Solutions

Line	Rev Cd	Units	Charges	NonCovChg	Description
01	134	5	2500.00	000.00	Psych/3&4 Bed
02	251	1	450.00	000.00	Drugs/Generic
03	301	32	400.00	000.00	Lab/Chemistry
04	302	1	150.00	000.00	Lab/Immunology
05	305	1	150.00	000.00	Lab/Hematology

Line	Rev Cd	Units	Charges	NonCovChg	Description
01	134	5	2500.00	000.00	Psych/3&4 Bed
02	251	1	450.00	450.00	Drugs/Generic
03	301	32	400.00	400.00	Lab/Chemistry
04	302	1	150.00	150.00	Lab/Immunology
05	305	1	150.00	150.00	Lab/Hematology

Invalid AHCCCS ID Removal

The CIS system edit prohibiting the RBHAs from removing an invalid AHCCCS ID from one of their intakes will be removed, allowing the RBHAs to remove AHCCCS IDs entered in error.

Removal of the AHCCCS ID is only allowed if the client is not currently, or never has been enrolled in the AHCCCS system. If the client has ever been enrolled in AHCCCS, the RBHA must correct, rather than remove, the invalid AHCCCS ID.

AHCCCS
Division of Health Care Management
Data Analysis & Research Unit
Encounter File Processing Schedule
October/November 2004

FILE PROCESSING ACTIVITY	Oct 2004	Nov 2004
Deadline for Corrected Pended Encounter and New Day File Submission to AHCCCS	Fri 10/08/04 12:00 PM	Fri 11/05/04 12:00 PM
Work Days for AHCCCS	6	6
Encounter Pended and Adjudication Files Available to Health Plans.	Tue 10/18/2004	Tue 11/15/2004
Work Days for Health Plans	18	13

NOTE:

1. This schedule is subject to change. If untimely submission of an encounter is caused by an AHCCCS schedule change, a sanction against timeliness error will not be applied.
2. Health Plans are required to correct each pending encounter within 120 days.
3. On deadline days, encounter file(s) must arrive at AHCCCS by 12:00 p.m., Noon, unless otherwise noted

Important Reminders . . .

AHCCCS Pended Encounter File Processing

ADHS has completed processing the backlog of the "new day" encounters at AHCCCS. ADHS continues to work with AHCCCS and the RBHAs to resolve outstanding processing issues. Below is a recap of "new day" backlog processing.

AHCCCS Cycle	"New Day" Data	Status
Jun 2004	Oct 2003 – Jan 2004	Processed
Jul 2004	Feb-Mar 2004	Processed
Aug 2004	Apr-Jun 2004	Processed
Sep 2004	Jul-Aug 2004	Processed
Oct 2004	Sep 2004	Scheduled

Due to the backlog in processing, AHCCCS is allowing the RBHAs more time to clean up pended encounters before they impose sanctions; however, ADHS is encouraging the RBHAs to correct their pends as soon as possible. The Pend_Days and Sanction_Date fields will help you prioritize the cleanup process.

- **Pend Deletions** - Send your pended encounter deletions through the daily void process. This will allow the pended encounters to be voided in CIS and deleted at AHCCCS in one step.
- **Pend Approved Duplicate Overrides** - Only send your pended encounter approved duplicate overrides in the DELDUPyyyymm_rr.TXT file.

If you have any questions regarding methods of handling particular error codes, please contact your assigned DBHS Technical Assistant.

Did You Know ???

User Access Request Forms

The Office of Program Support Services must authorize all requests for access to CIS, Office of Human Rights, Office of Grievance and Appeals, Issue Resolution System, and PMMIS (AHCCCS) databases. In order to obtain access to any of these databases, please fax or mail a copy of the appropriate User Access Request Form and User Affirmation Statement to Stacy Mobbs at (602) 364-4736.

For questions, please contact Stacy Mobbs by telephone at (602) 364-4708 or by e-mail at smobbs@hs.state.az.us.

AHCCCS Encounters Error Codes

R600 – Medicare Coverage Indicated But Not Billed

Encounters are pending because the TPL file indicates the recipient has Medicare coverage, but the claim was submitted with the Medicare fields blank. If the TPL file indicates a recipient has Medicare, claims must be submitted with a dollar amount. If the service is not a Medicare covered service, zero must be entered in the Medicare fields, indicating Medicare did not cover or denied the service.

Z725 – Exact Duplicate from Different Health Plans

Encounters are pending because at least one claim was found in the system from another health plan matches the pended claim. These claims need to be researched by both health plans' to determine the cause for the exact duplicate. Each health plan must work together to resolve the issue and decide who should receive payment for the service. Your assigned technical assistant is available to help you with your research.

P330 – Provider Not Eligible for Category of Service on Service Date

Review all pertinent fields and relevant data on the encounter. The most common error is an inappropriate procedure code. Review the AHCCCS PMMIS Encounter/Claims screen PR035 Categories of Service and PR090 Provider Profile for appropriate data. If the problem cannot be resolved, contact the appropriate technical assistant.

Z725 – Exact Duplicate from Different Health Plans	54,441
R600 – Medicare Coverage Indicated But Not Billed	959
P330 – Provider Not Eligible for COS on Service Date	2,520
Total	57,920

*These errors account for **80.28%** of the pended encounters at AHCCCS.*

Billing Questions ……

Upcoding and Medical Necessity

Q I would like to know more about what is considered upcoding. As coders we are involved with meeting medical necessity on our claims. Sometimes to meet medical necessity, a code that we would not normally pick up but is documented is the only one that meets medical necessity.

An example is a patient that comes through the ED for weakness in their arms and legs. A PT evaluation is ordered, but the code for weakness does not meet medical necessity for the evaluation. In the H&P, urinary incontinence is documented, which does meet medical necessity. If that code is added, would that be considered upcoding?

A Upcoding is the practice of submitting codes at a level or frequency that is not supported by documentation, or billing of a more complex procedure when a less complex procedure was completed.

This is a tricky area. Technically, if the patient has a covered diagnosis the service is a covered service. However, I strongly caution any practice or facility against routinely searching for covered diagnoses just so a test or service is paid. If the patient has the condition, sign, symptom, or disease that is coded, generally there would not be a problem.

However, the scenario as written has serious ethical problems, in my opinion. Documentation, if reviewed, would show the reason the test was ordered was not the reason that was submitted on the claim form.

As stated, if the patient has urinary incontinence, the procedure would still be a covered procedure, but an outside auditor that found this pattern of coding might question the validity of other claims. This is not upcoding.

This question was answered by Susan Welsh, CPC, director of coding and education, Physician Services, Ethics and Compliance, HCA.

Office of Program Support Staff

If you need assistance, please contact your assigned Technical Assistant at:

Michael Carter	Excel NARBHA	(602) 364-4710
Eunice Argusta	CPSA-3 CPSA-5 Gila River Navajo Nation Pascua Yaqui	(602) 364-4711
Javier Higuera	PGBHA Value Options	(602) 364-4712